MEDICARE ADVANTAGE
PARTICIPATION ATTACHMENT TO THE
ANTHEM BLUE CROSS AND BLUE SHIELD
PROVIDER AGREEMENT

This is a Participation Attachment to the Anthem Blue Cross and Blue Shield Provider Agreement ("Agreement"), entered into by and between Anthem and Provider and is incorporated into the Agreement.

ARTICLE I
DEFINITIONS

The following definitions shall apply to this Medicare Advantage Participation Attachment:

1.1 "Clean Claim" means a Claim that has no defect or impropriety, including a lack of required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payment from being made on the Claim. A Claim is clean even though Plan refers it to a medical specialist within Plan for examination. If additional documentation (e.g., a medical record) involves a source outside Plan, then the Claim is not considered clean.

1.2 "Covered Individual" means, for purposes of this Attachment, a Medicare beneficiary covered under a Medicare agreement between CMS and Plan under Part C of Title XVIII of the Social Security Act ("Medicare Advantage Program").

1.3 "Emergency or Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

1.4 "Emergency Services" means covered inpatient and outpatient Health Services that are: (1) furnished by a provider qualified to furnish emergency services; and (2) needed to evaluate or stabilize an Emergency Medical Condition.

1.5 "CMS" means the Centers for Medicare and Medicaid Services.

1.6 "Downstream Entity(ies)" means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between Anthem and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

1.7 "First Tier Entity(ies)" means any party that enters into a written agreement, acceptable to CMS, with Anthem or applicant to provide administrative services or health care services for a Medicare eligible individual under the Medicare Advantage Program.

1.8 "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Act, as then constituted or later amended.

1.9 "Related Entity(ies)" means any entity that is related to Anthem by common ownership or control and (1) performs some of Anthem's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to Anthem at a cost of more than twenty-five hundred dollars ($2,500) during a contract period.

1.10 "Urgently Needed Care" means Covered Services provided when a Covered Individual is either:

1.10.1 Temporarily absent from Plan's Medicare Advantage service area and such Covered Services are Medically Necessary and immediately required: (1) as a result of an unforeseen illness, injury, or condition; and (2) it was not reasonable, given the circumstances, to obtain the services through Plan's Medicare Advantage Network; or

1.10.2 Under unusual and extraordinary circumstances, the Covered Individual is in the service area but Plan's provider Network is temporarily unavailable or inaccessible and such Covered Services are
Medically Necessary and immediately required: (1) as a result of an unforeseen illness, injury, or condition; and (2) it was not reasonable, given the circumstances, to obtain the services through Plan's Medicare Advantage Network.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Participation-Medicare Advantage. As a participant in Plan's Medicare Advantage Program, Provider will render Covered Services to Covered Individuals enrolled in Plan's Medicare Advantage Program in accordance with the terms and conditions of the Agreement and this Attachment. Except as set forth in this Attachment, or the Plan Compensation Schedule ("PCS") attached to the Agreement, all terms and conditions of the Agreement will apply to Provider's participation in Plan's Medicare Advantage Program(s). This Agreement does not apply to any of the Plan's Medicare Advantage Private Fee for Service or Medical Savings Account Programs or Medicare Advantage plans managed or administered by CareMore, LLC unless otherwise agreed to by the parties and set forth in the PCS.

2.2 Participation-Out of Area Programs. Pursuant to the Blue Cross and Blue Shield Out of Area Program section of the Agreement, Provider hereby acknowledges and agrees that Provider shall provide Covered Services to any person who is covered under another Blue Cross and Blue Shield Plan under the Blue Cross and Blue Shield Association Out of Area Program, including, but not limited to, a network sharing PPO developed to support Medicare Advantage Programs.

2.3 Participation-Medicare Advantage Program. By virtue of the fact that Provider is a Medicare Advantage Network/Participating Provider, Provider hereby acknowledges and agrees that Provider shall provide services to any Medicare Advantage Covered Individual enrolled in a Plan insured product that utilizes the Medicare Advantage Network.

2.4 Covered Individual/Covered Service-Defined. The parties agree that all references in the Agreement to Covered Individual(s) include Covered Individuals of Plan's Medicare Advantage Program and all references to Covered Services include services offered pursuant to Plan's Medicare Advantage Program.

2.5 Medical Necessity. Medical Necessity decisions regarding Covered Individuals will be made in compliance with CMS guidelines.

2.6 Accountability/Oversight. Plan delegates to Provider its responsibility under its Medicare Advantage contract with CMS to provide the services as set forth in this Attachment to Covered Individuals. Plan may revoke this delegation, including, if applicable, the delegated responsibility to meet CMS reporting requirements, and thereby terminate the Attachment if CMS or Plan determine that Provider has not performed satisfactorily. Such revocation shall be consistent with the termination provisions of this Attachment. Performance of the Provider shall be monitored by Plan on an ongoing basis as provided for in this Attachment. Provider further acknowledges that Plan is accountable to CMS for the functions and responsibilities described in the Medicare Advantage regulatory standards and ultimately responsible to CMS for the performance of all services. Provider acknowledges that Plan shall oversee and is accountable to CMS for the functions and responsibilities described in the Medicare Advantage regulatory standards. Further, Provider acknowledges that Plan may only delegate such functions and responsibilities in a manner consistent with the standards as set forth in 42 CFR §422.504(i)(4).

2.7 Accountability/Credentialing. Both parties acknowledge that accountability shall be in a manner consistent with the requirements as set forth in 42 CFR §422.504(i)(4). Therefore the following are acceptable for purposes of meeting these requirements:

2.7.1 The credentials of medical professionals affiliated with the Plan or the Provider will be either reviewed by the Plan if applicable; or

2.7.2 The credentialing process will be reviewed and approved by the Plan and the Plan must audit the Provider's credentialing process and/or delegate's credentialing process on an ongoing basis.

2.8 Medicare Provider. Provider must have a provider and/or supplier agreement, whichever is applicable, with CMS that permits them to provide services under original Medicare.

ARTICLE III
ACCESS: RECORDS/FACILITIES
3.1 **Inspection of Books/Records.** Provider acknowledges that Plan, Health and Human Services department (HHS), the Comptroller General, or their designees have the right to timely access to inspect, evaluate and audit any books, contracts, medical records, patient care documentation, and other records of Provider, or his/her/its First Tier, Downstream and Related Entities, including but not limited to subcontractors or transferees involving transactions related to Plan's Medicare Advantage contract through ten (10) years from the final date of the contract period or from the date of the completion of any audit, or for such longer period provided for in 42 CFR § 422.504(e)(4) or other applicable law, whichever is later. For the purposes specified in this section. Provider agrees to make available Provider's premises, physical facilities and equipment, records relating to Plan's Covered Individuals, including access to Provider's computer and electronic systems and any additional relevant information that CMS may require. Provider acknowledges that failure to allow HHS, the Comptroller General or their designees the right to timely access under this section can subject Provider to a fifteen thousand dollar ($15,000) penalty for each day of failure to comply.

3.2 **Confidentiality.** Each party agrees to abide by all federal and state laws applicable to that party regarding confidentiality and disclosure for mental health records, medical records, other health information, and enrollee information. Provider agrees to maintain records and other information with respect to Covered Individuals in an accurate and timely manner; to ensure timely access by enrollees to the records and information that pertain to them; and to safeguard the privacy of any information that identifies a particular enrollee. Information from, or copies of, records may be released only to authorized individuals. Provider must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released only in accordance with federal or state laws, court orders or subpoenas. Both parties acknowledge that Plan, HHS, the Comptroller General or its designee have the right, pursuant to section 3.1 above, to audit and/or inspect Provider's premises to monitor and ensure compliance with the CMS requirements for maintaining the privacy and security of protected health information (PHI) and other personally identifiable information of Covered Individuals.

**ARTICLE IV**  
**ACCESS: BENEFITS AND COVERAGE**

4.1 **Non-Discrimination.** Provider shall not deny, limit, or condition the furnishing of Health Services to Covered Individuals of Plan on the basis of any factor that is related to health status, including, but not limited to medical condition; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; or disability.

4.2 This provision intentionally left blank.

4.3 **Direct Access.** Provider acknowledges that Covered Individuals may obtain covered mammography screening services and influenza vaccinations from a participating provider without a referral and that Covered Individuals who are women may obtain women's routine and preventive Health Services from a participating women's health specialist without a referral.

4.4 **No Cost Sharing.** Provider acknowledges that covered influenza vaccines and pneumococcal vaccines are not subject to Covered Individual Cost Share obligations.

4.5 **Timely Access to Care.** Provider agrees to provide Covered Services consistent with Plan's: (1) standards for timely access to care and member services; (2) policies and procedures that allow for individual Medical Necessity determinations; and (3) policies and procedures for the Provider's consideration of Covered Individual input in the establishment of treatment plans.

4.6 **Continuity of Care.** A Provider who is a Primary Care Provider, or a gynecologist or obstetrician, shall provide Health Services or make arrangements for the provision of Health Services to Covered Individuals on a twenty-four (24) hour per day, seven (7) day a week basis to assure availability, adequacy and continuity of care to Covered Individuals. In the event a Provider is not one of the foregoing described providers, then Provider shall provide Health Services to Covered individuals on a twenty-four (24) hour per day, seven (7) day a week basis or at such times as Health Services are typically provided by similar providers to assure availability, adequacy, and continuity of care to Covered Individuals. If Provider is unable to provide Health Services as described in the previous sentence, Provider will arrange for another Network/Participating Provider to cover Provider's patients in Provider's absence.

**ARTICLE V**  
**BENEFICIARY PROTECTIONS**
5.1 **Cultural Competency.** Provider shall ensure that Covered Services rendered to Covered Individuals, both clinical and non-clinical, are accessible to all Covered Individuals, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities. Provider must provide information regarding treatment options in a culturally-competent manner, including the option of no treatment. Provider must ensure that individuals with disabilities have effective communications with participants throughout the health system in making decisions regarding treatment options.

5.2 **Health Assessment.** Provider acknowledges that Plan has procedures approved by CMS to conduct a health assessment of all new Covered Individuals within ninety (90) days of the effective date of their enrollment. Provider agrees to cooperate with Plan as necessary in performing this initial health assessment.

5.3 **Identifying Complex and Serious Medical Condition.** Provider acknowledges that Plan has procedures to identify Covered Individuals with complex or serious medical conditions for chronic care improvement initiatives; and to assess those conditions, including medical procedures to diagnose and monitor them on an ongoing basis; and establish and implement a treatment plan appropriate to those conditions, with an adequate number of direct access visits to specialists to accommodate the treatment plan. To the extent applicable, Provider agrees to assist in the development and implementation of the treatment plans and/or chronic care improvement initiatives.

5.4 **Advance Directives.** Provider shall establish and maintain written policies and procedures to implement Covered Individuals' rights to make decisions concerning their health care, including the provision of written information to all adult Covered Individuals regarding their rights under state and federal law to make decisions regarding their right to accept or refuse medical treatment and the right to execute an advance medical directive. Provider further agrees to document or oversee the documentation in the Covered Individuals' medical records whether or not the Covered Individual has an advance directive, that Provider will follow state and federal requirements for advance directives and that Provider will provide for education of his/her/its staff and the community on advance directives.

5.5 **Standards of Care.** Provider agrees to provide Covered Services in a manner consistent with professionally recognized standards of health care.

5.6 **Hold Harmless.** Provider agrees that in no event, including but not limited to non-payment by Plan, insolvency of Plan or breach of the Agreement, shall the Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Individual or persons other than Plan acting on their behalf for Covered Services provided pursuant to the Agreement. This section does not prohibit the collection of supplemental charges or Cost Shares on Plan's behalf made in accordance with the terms of the Covered Individual's Health Benefit Plan or amounts due for services that have been correctly identified in advance as a non-Covered Service, subject to medical coverage criteria, with appropriate disclosure to the Covered Individual of their financial obligation. This advance notice must be provided in accordance with the CMS regulations for Medicare Advantage organizations. CMS regulations require that a coverage determination be made with a standard denial notice (Notice of Denial of Medical Coverage (or Payment)/CMS-10003) for a non-Covered Service or item when such service or item is typically not covered, but could be covered under specific conditions. If prior to rendering the service or item, Provider obtains, or instructs the Covered Individual to obtain, a coverage determination of a non-covered item or service, the Covered Individual can be held financially responsible for non-Covered Services or items. However, if a service or item is never covered by the Plan, such as a statutory exclusion, and the Covered Individual's Evidence of Coverage (“EOC”) clearly specifies that the service or item is never covered, the Provider does not have to seek a coverage determination from Anthem in order to hold the Covered Individual responsible for the full cost of the service or item. Additional information, related requirements and the process to request a coverage determination can be found in the Provider Guidebook. Both Parties agree that failure to follow the CMS regulations can result in Provider's financial liability.

5.6.1 Provider further agrees that for Covered Individuals who are dual eligible enrollees for Medicare and Medicaid, that Provider will ensure they will not bill the Covered Individual for Cost Sharing that is not the Covered Individual's responsibility and such Covered Individuals will not be held liable for Medicare Parts A and B Cost Sharing when the State is liable for the Cost Sharing. In addition, Provider agrees to accept the Plan payment as payment in full or by billing the appropriate state source.

5.7 **Continuation of Care-Insolvency.** Provider agrees that in the event of Plan's insolvency, termination of the
CMS contract or other cessation of operations, Covered Services to Covered Individuals will continue through the period for which the premium has been paid to Plan, and services to Covered Individuals confined in an inpatient hospital on the date of termination of the CMS contract or on the date of insolvency or other cessation of operations will continue until their discharge.

5.8 Survival of Attachment. Provider further agrees that: (1) the hold harmless and continuation of care sections shall survive the termination of the Covered Individual; (2) these provisions supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and a Covered Individual or persons acting on their behalf that relates to liability for payment for, or continuation of, Covered Services provided under the terms and conditions of these clauses; and (3) any modifications, addition or deletion to these provisions shall become effective on a date no earlier than fifteen (15) days after the Administrator of CMS has received written notice of such proposed changes.

5.8.1 Survival after Termination. To the extent the Agreement terminates before this Attachment, the parties agree that all necessary terms of the Agreement will survive to allow continuation of this Attachment until the effective date of the termination of the Attachment.

ARTICLE VI
COMPENSATION AND FEDERAL FUNDS

6.1 Compensation-Medicare Advantage. For Covered Services provided to Covered Individuals, Provider shall be compensated in accordance with the Anthem Medicare Advantage Rate in effect at the time the Covered Service is rendered, and as set forth in the PCS attached to the Agreement. Such PCS may be amended from time to time as provided for in the Agreement.

6.1.1 For purposes of determining the Anthem Medicare Advantage Rate (as set forth above) under this Agreement for Covered Services furnished to Covered Individuals, any reimbursement methodologies in this Agreement that are based in whole or in part upon Medicare rates, pricing, fee schedules or payment methodologies published or established by CMS, shall refer to the per claim payment amount that CMS and a fee for service member would pay to Provider for the same items or services directly under Medicare Part A or Part B. The Anthem Medicare Advantage Rate shall not include any bonus payment or settlement amount paid to Provider by CMS outside the claim payment process, unless otherwise set forth herein. Absent notification to the contrary, in the event CMS changes compensation to Provider for a Covered Service as a result of a CMS directive, Act of Congress, Executive Order, or a change in regulatory requirement(s), the amount payable to Provider hereunder will automatically be changed as soon as is reasonably practicable, as described above, in the amount specified by CMS as a result of such directive or change in law, or in the absence of such specification, in the same percentage amount as payment is changed by CMS to Provider.

6.2 Prompt Payment. Plan agrees to make best efforts to pay a majority of Clean Claims for Covered Services submitted by or on behalf of Covered Individuals, within forty-five (45) days of receipt by Plan. Plan agrees to make best efforts to pay all remaining Clean Claims for Covered Services submitted by or on behalf of Covered Individuals, within sixty (60) days of receipt by Plan. Plan agrees to make best efforts to pay all non-Clean Claims for Covered Services submitted by or on behalf of Covered Individuals within sixty (60) days of receipt by Plan of the necessary documentation to adjudicate the Claim.

6.3 Federal Funds. Provider acknowledges that payments Provider receives from Plan to provide Covered Services to Covered Individuals are, in whole or part, from federal funds. Therefore, Provider and any of his/her/its subcontractors are subject to certain laws that are applicable to individuals and entities receiving federal funds, which may include but is not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973 and any other regulations applicable to recipients of federal funds.

6.4 Overpayments/Adjustments/Recoveries. Notwithstanding any terms and conditions of the Agreement, Plan has the same rights as CMS and will follow the CMS time frames for review and audit of all Claims for compliance with applicable CMS regulations and instruction. Plan shall be entitled to offset or recoup any overpayments or improper payments made by Plan to Provider against any payments due and payable by Plan under this Agreement. Provider shall voluntarily refund all duplicate or erroneous Claim payments regardless of the cause, including but not limited to, Claims that were miscoded, non-compliant with industry standards, the services provided do not meet medical necessity requirements, or otherwise billed in error,
whether or not the billing was fraudulent, abusive or wasteful. Upon determination by Plan that any recoupment, improper payment, or overpayment is due from Provider, Provider must refund such amounts to the Plan within thirty (30) days of when Plan notifies Provider. If such reimbursement is not received by Plan within the thirty (30) days following the date of such notice, Plan shall be entitled to offset such overpayment against any subsequent amounts due and payable by Plan to Provider in accordance with any applicable CMS regulatory requirements. Plan reserves the right to employ a third party collection agency in the event of non-payment.

ARTICLE VII
REPORTING AND DISCLOSURE REQUIREMENTS

7.1 Risk Adjustment Data Validation Audits. Plan and Provider are required in accordance with 42 CFR § 422.310(e) to submit a sample of medical records for Covered Individuals for the purpose of validation of risk adjustment data. Accordingly, Plan, or their designee, shall have the right, as set forth in section 3.1 to obtain copies of such documentation on at least an annual basis. Provider agrees to provide the requested medical records to Plan, or their designee, within fourteen (14) calendar days from Plan's, or their designee's, written request. Such records shall be provided to Plan, or their designee, at no additional cost.

7.2 Data Reporting Submissions. Provider agrees to provide to Plan all information necessary for Plan to meet its data reporting and submission obligations to CMS, including but not limited to, data necessary to characterize the context and purpose of each encounter between a Covered Individual and the Provider ("Risk Adjustment Data"), and data necessary for Plan to meet its reporting obligations under 42 CFR §§ 422.516 and 422.310. In accordance with the CMS requirements, the Plan reserves the right to assess Provider for any penalties resulting from Provider's submission of false data.

7.3 Risk Adjustment Data. Provider's Risk Adjustment Data shall include all information necessary for Plan to submit such data to CMS as set forth in 42 CFR § 422.310 or any subsequent or additional regulatory provisions. If Provider fails to submit his/her/its Risk Adjustment Data accurately, completely and truthfully, in the format described in the 42 CFR § 422.310 or any subsequent or additional regulatory provisions, then this will result in denials and/or delays in payment of Provider's Claims.

7.4 Accuracy of Risk Adjustment Data. Provider further agrees to certify the accuracy, completeness, and truthfulness of Provider generated Risk Adjustment Data that Plan is obligated to submit to CMS. Within thirty (30) days after the beginning of every Fiscal Year or as required by CMS while the Medicare Advantage Participation Attachment is in effect, Provider agrees to give Plan a certification in writing, in a format that Plan specifies, that certifies to the accuracy, completeness, and truthfulness of Provider's Risk Adjustment Data submitted to Plan during the specified period.

ARTICLE VIII
QUALITY ASSURANCE/QUALITY IMPROVEMENT REQUIREMENTS

8.1 Independent Quality Review Organization. Provider agrees to comply and cooperate with an independent quality review and improvement organization's activities pertaining to the provision of Covered Services for Covered Individuals.

8.2 Compliance with Plan Medical Management Programs. Provider agrees to comply with Plan's medical policies, quality improvement and performance improvement programs, and medical management programs to the extent provided to or otherwise made available to Provider in advance.

8.3 Consulting with Network/Participating Providers. Plan agrees to consult with Network/Participating Providers regarding its medical policies, quality improvement program and medical management programs and ensure that practice guidelines and utilization management guidelines: (1) are based on reasonable medical evidence or a consensus of health care professionals in the particular field; (2) consider the needs of the enrolled population; (3) are developed in consultation with participating physicians; (4) are reviewed and updated periodically; and (5) are communicated to providers and, as appropriate, to Covered Individuals. Plan also agrees to ensure that decisions with respect to utilization management, Covered Individual education, coverage of Health Services, and other areas in which the guidelines apply are consistent with the guidelines.

ARTICLE IX
COMPLIANCE
9.1 **Compliance: Medicare Laws/Regulations.** Provider agrees to comply, and to require any of his/her/its subcontractors to comply, with all applicable Medicare laws, regulations, and CMS instructions. Further, Provider agrees that any Covered Services provided by the Provider or his/her/its subcontractors to or on behalf of the Plan’s Covered Individuals will be consistent with and will comply with Plan’s Medicare Advantage contractual obligations.

9.2 **Compliance: Exclusion from Federal Health Care Program.** Provider may not employ, or subcontract with an individual, or have persons with ownership or control interests, who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, or social services programs under Title XX of the Social Security Act, and thus have been excluded from participation in any federal health care program under §§ 1128 or 1128A of the Act (or with an entity that employs or contracts with such an individual) for the provision of any of the following:

9.2.1 healthcare;

9.2.2 utilization review;

9.2.3 medical social work; or

9.2.4 administrative services.

9.3 **Compliance: Appeals/Grievances.** Provider agrees to comply with Plan’s policies and procedures in performing his/her/its responsibilities under the Agreement. Provider specifically agrees to comply with Medicare requirements regarding Covered Individual appeals and grievances and to cooperate with Plan in meeting its obligations regarding Covered Individual appeals, grievances and expedited appeals, including the gathering and forwarding of information in a timely manner and compliance with appeals decisions.

9.4 **Compliance: Policy and Procedures.** Provider agrees to comply with Plan’s policy and procedures in performing his/her/its responsibilities under the Agreement and this Attachment including any supplementary documents that pertain to Plan’s Medicare Advantage Program such as the Product Guide.

9.5 **Illegal Remuneration.** Both parties specifically represents and warrants that activities to be performed under this Agreement are not considered illegal remunerations (including kickbacks, bribes or rebates) as defined in 42 USCA § 1320(a)-7b.

9.6 **Compliance: Training, Education and Communications.** In accordance with, but not limited to 42 CFR §§ 422.503(b)(4)(vi)(C)&(D) and 423.504(b)(4)(vi)(C)&(D), Provider agrees and certifies that it, as well as its employees, subcontractors, Downstream Entities, Related Entities and agents who provide services, to or for Plan’s Medicare Advantage and/or Part D Covered Individuals or to or for the Plan itself, shall participate in applicable compliance training, education and/or communications as reasonably requested by the Plan or its designee annually or as otherwise required by applicable law, and must be made a part of the orientation for a new employee, new First Tier, Downstream or Related Entity and for all new appointments of a chief executive, manager, or governing body member. Both parties agree that the Plan or its designee may make such compliance training, education and lines of communication available to Provider in either electronic, paper or other reasonable medium. Provider shall be responsible for documenting applicable employee’s, subcontractor’s, Downstream Entity’s, Related Entity’s and/or agent’s attendance and completion of such training. Upon notice, Provider shall provide such documentation to Plan, unless otherwise not required by CMS regulation. In addition, the training requirement set forth herein is not required for providers or suppliers who have met the fraud, waste and abuse certification requirements through enrollment into the Medicare program, as those providers and/or suppliers are deemed to have met that portion of the fraud waste and abuse training required by CMS.

**ARTICLE X**

**MARKETING**

10.1 **Approval of Materials.** Both parties agree to comply, and to require any of his/her/its subcontractors to comply, with all applicable federal and state laws, regulations, CMS instructions, and marketing activities under this Agreement, including but not limited to, the Medicare Marketing Guidelines for Medicare Managed Care Plans and any requirements for CMS prior approval of materials. Any printed materials, including but not limited to letters to Plan Covered Individuals, brochures, advertisements, telemarketing scripts, packaging prepared or produced by Provider or any of his/her/its subcontractors pursuant to this Agreement must be submitted to Plan for review and approval at each planning stage (i.e., creative, copy, mechanicals,
blue lines, etc.) to assure compliance with federal, state, and Blue Cross/Blue Shield Association guidelines. Plan agrees its approval will not be unreasonably withheld or delayed.

**ARTICLE XI**
**TERM AND TERMINATION**

11.1 **Notice Upon Termination.** If Plan decides to terminate this Attachment, Plan shall give Provider written notice, to the extent required under CMS regulations, of the reasons for the action, including, if relevant, the standards and the profiling data the organization used to evaluate Provider and the numbers and mix of Network/Participating Providers Plan needs. Such written notice shall also set forth Provider’s right to appeal the action and the process and timing for requesting a hearing.

11.2 **Termination for Medicare Exclusion.** Provider acknowledges that this Attachment shall be terminated if Provider, or a person or entity with ownership or control interest in Provider, is excluded from participation in Medicare under § 1128A of the Social Security Act or from participation in any other federal health care program.

11.3 **Termination Without Cause.** Either party may terminate this Medicare Advantage Participation Attachment without cause by giving at least one hundred eighty (180) days prior written notice of termination to the other party. Upon your notice of Termination Without Cause, Provider is required to notify Covered Individual(s) sixty (60) days prior to your effective date of termination with Anthem.

11.4 **Term/Termination.** This Attachment shall continue in effect unless otherwise terminated as provided for in this Attachment or in the Agreement.

**ARTICLE XII**
**GENERAL PROVISIONS**

12.1 **Inconsistencies.** In the event of an inconsistency between terms of this Attachment and the terms and conditions as set forth in the Agreement, the terms and conditions of this Attachment shall govern. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

12.2 **Interpret According to Medicare Laws.** Provider and Plan intend that the terms of the Agreement and this Attachment as they relate to the provision of Covered Services under the Medicare Advantage Program shall be interpreted in a manner consistent with applicable requirements under Medicare law.

12.3 **Subcontractors.** Provider agrees that if Provider enters into subcontracts to perform services under the terms of this Attachment, Provider’s subcontracts shall include: (1) an agreement by the subcontractor to comply with all of the Provider’s obligations in the Agreement and this Attachment; (2) a prompt payment provision as negotiated by the Provider and the subcontractor; (3) a provision setting forth the term of the subcontract (preferably one (1) year or longer); and (4) dated signatures of all the parties to the subcontract.

12.4 **Delegated Activities.** If Plan has delegated activities to Provider, then the Plan will provide the following information to Provider and Provider shall provide such information to any of its subcontracted entities:

12.4.1 A list of delegated activities and reporting responsibilities;

12.4.2 Arrangements for the revocation of delegated activities;

12.4.3 Notification that the performance of the contracted and subcontracted entities will be monitored by the Plan;

12.4.4 Notification that the credentialing process must be approved and monitored by the Plan; and

12.4.5 Notification that all contracted and subcontracted entities must comply with all applicable Medicare laws, regulations and CMS instructions.

12.5 **Delegation of Provider Selection.** In addition to the responsibilities as set forth in section 12.4 above, to the extent that Plan has delegated selection of the providers, contractors, or subcontractor to Provider, the Plan retains the right to approve, suspend, or terminate any such arrangement.